DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

ROUTINE MEDICAL SURVEY
OF
A FULL SERVICE PLAN

FINAL REPORT

HEALTH NET of CALIFORNIA, INC.

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CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Routine Medical Survey of Health Net of California, Inc. (the "Plan") from January 31, 2005 to February 3, 2005. This is a Final Report of findings and deficiencies from this Routine Medical Survey. The Department conducts a Routine Medical Survey of each licensed health care service plan at least once every three (3) years to evaluate compliance with the requirements of the Knox-Keene Act. The Survey addresses four (4) areas: Quality Management, Grievances and Appeals, Access and Availability of Services, and Utilization Management.

Background

The Plan was founded as a non-profit corporation in 1977 and was licensed by the Department of Insurance as a hospital service plan. The Plan was approved as a federally qualified health maintenance organization (HMO) by the Centers for Medicare and Medicaid in 1977. In 1991, the Plan converted to for-profit status and became licensed under the Act by the Department of Corporations.

In 1994, the Plan merged with QualMed Plans for Health, and the new parent company was named Health Systems International, Inc. In April 1997, Health Systems International, Inc. merged with Foundation Health Corporation and the resulting parent company was named Foundation Health System, Inc. In California, Health Net and Foundation Health Corporation's subsidiary health plan, Foundation Health, a California health plan, merged in January 1998. In November 2000, Foundation Health System, Inc. changed its name to Health Net, Inc. and Health Net changed its name to Health Net of California, Inc., a publicly-traded company. Beginning in 2002, there was a shift in administrative duties to a more centralized corporate structure; several functions including the Customer Call Center, credentialing and claims were transferred to the national corporate entity.

The Plan serves members in 30 California counties through its commercial HMO and Point of Service product lines.

Survey Results

The Plan had no deficiencies outstanding from the previous Routine Medical Survey that would have required follow-up assessment during this current Routine Medical Survey. (See Section II.A.).

The Department identified five (5) compliance deficiencies during the current Routine Medical Survey (see Section II.B., Table 2). The Plan has implemented corrective actions for these deficiencies. The Plan has corrected two (2) of the five (5) deficiencies. One (1) deficiency in the area of Access and Availability of Services and two (2) deficiencies in the area of Utilization Management remain uncorrected at the time of this Final Report.

See Appendix A for an explanation of the Department's approach in surveying California health plans licensed by the Department.

SECTION I. SURVEY HISTORY

The table below is a schedule of survey activities conducted by the Department at the Plan in the past three (3) years.

TABLE 1

SURVEY ACTIVITY	DATE(S)
2002 Routine Survey On-Site Visit	February 18 - 21, 2002
2002 Preliminary Report Issued	May 21, 2002
Final Report for 2002 Routine Survey	August 6, 2002
Follow-up Report Issued to Plan	February 2, 2004
2005 Routine Survey On-Site Visit	January 31 - February 3, 2005
2005 Preliminary Report Issued	April 22, 2005
2005 Routine Survey Final Report Issued	July 25, 2005

See Appendix B for a list of Enforcement Action(s) taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

SECTION II. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

A. OUTSTANDING DEFICIENCIES FROM FOLLOW-UP REPORT

At the time the Department initiated the current medical survey, the Plan had no deficiencies outstanding from the previous medical survey cycle.

B. 2005 SURVEY DEFICIENCIES

The table below lists deficiencies identified during the current survey. The Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 2

SUMMARY OF 2005 SURVEY DEFICIENCIES		
#	**DEFICIENCY**	**STATUS**
GRIEVANCES AND APPEALS		
1	**The Plan does not consistently: (a) acknowledge receipt of appeals within five (5) calendar days of Plan receipt of the grievance/appeal ; and (b) provide the enrollees with a clear and concise explanation for the Plan's decision.** [Rule 1300.68(d)(1); Section 1368(a)(4)]	Corrected
2	**The Plan does not appear to immediately notify enrollees of their rights to notify the Department in times of urgent grievances.** [Rule 1300.68.01(a) (4), Section 1368.01(b)]	Corrected
ACCESS AND AVAILABILITY OF SERVICES		
3	**The Plan does not have a documented system for monitoring and evaluating the availability of providers that includes a system for addressing suspected problems.** [Rule 1300.67.2(f)]	Not Corrected

UTILIZATION MANAGEMENT		
4	**For retrospective reviews, the Plan does not consistently complete its review within 30 days of receipt of medical information necessary to make a determination.** [Section 1367.01(h)(1)]	Not Corrected
5	**The Plan does not adequately ensure that delegated providers follow the prudent layperson standard when reviewing emergency services.** [Sections 1367.01(a) and 1371.4(c)]	Not Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

GRIEVANCES and APPEALS

Deficiency 1: The Plan does not consistently:
(a) acknowledge receipt of appeals within five (5) calendar days of Plan receipt of the grievance/appeal ; and
(b) provide the enrollees with a clear and concise explanation for the Plan's decision. [Rule 1300.68(d)(1); Section 1368(a)(4)]

Documents Reviewed:

- 20 standard appeal files from the time period July 2004 to December 2004
- 10 urgent appeal files from the time period July 2004 to December 2004
- 45 grievance files from the time period July 2004 to December 2004

Department Findings: The Department reviewed 20 standard appeals, 10 urgent appeals, and 45 grievance files. Table 3 below summarizes the Department's findings:

TABLE 3

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Appeal files (standard and urgent)	30	Acknowledgement within five calendar days of the plan's receipt of a grievance	24 (80%)	6 (20%)
Grievance files (QOC and QOS)	45	Same as above	45 (100%)	0
Appeal files (standard and urgent)	30	Clear and concise explanation for the plan's decision	30 (100%)	0
Grievance files (QOC and QOS)	45	Same as above	32 (71%)	13 (29%)

The following examples demonstrate the lack of clarity in some of the Plan's resolution letters:

(1) An enrollee complained about the poor quality of care received from a provider, the unusual length of time to obtain an appointment, and requested a transfer to another provider. While the Plan did a thorough job investigating the case and made the appropriate referrals to the quality review RN, peer review committee and Provider Relations Unit for tracking and provider- counseling for better access, the generic resolution letter used by the Plan failed to address all the issues such as the enrollee's request for transfer to another provider.

(2) An enrollee disputed a medical claim. The Plan's resolution letter simply informed the enrollee that the matter had been investigated and that it had been referred to Claims for processing. It did not inform the enrollee whether the claim would be paid, and, if so, what amount would be paid.

Implications: Timely acknowledgment of grievances and clear communication of the Plan's decision are essential components of a fair and effective grievance system.

Corrective Action: The Plan shall submit evidence that it consistently:

- Acknowledges grievances within five (5) calendar days of receipt of the grievance; and
- Provides a clear and concise explanation for its decision and that it completely addresses enrollees' complaints in its resolution letters.

Plan's Compliance Effort: The Plan stated that, following implementation of corrective actions, its internal acknowledgment letter compliance reports now indicate a compliance rate of 94-95% for the period of February through April 26, 2005. The Plan's internal compliance goal is 90%.

The Plan stated that it performed an analysis of cases with late acknowledgment letters and determined that most were initiated and submitted late to the Appeals and Grievances (A&G) Department by the Member Services Department (MS Department). The two main reasons were:

1. Member issues were submitted to the A&G Department with insufficient information to properly address the member's concern. These incomplete cases were returned to the MS Department for more information and were not handled and/or resubmitted in a timely manner.

2. The Member Service representative either unsuccessfully attempted to resolve the complaint within the 24-hour timeframe (required by the Plan's first contact resolution process) or requested more information from the member which was not submitted in a timely manner.

The two departments developed and implemented the following new processes to prevent late submission of member issues to the A&G Department:

1. Member issues submitted with insufficient information will no longer be returned to MS Department. Instead the Classification Team (triage team) in the A&G Department will contact the member to acquire the needed information.

2. Member issues that cannot be resolved within the first contact resolution process will be forwarded to the A&G Department even when additional information is pending from the member.

The Plan stated that it created a report to identify Member Services Representatives that repeatedly submit late cases to the A&G Department to identify training and guidance needs and educated staff about the importance of the appeal/grievance initiation date. Additionally, a team of skilled letter writers reviewed the deficient case files identified by the Department and, based on the issues identified, revised the quality of care grievance template letters, created new quality of service grievance template letters, provided a letter writing training program and worked with auditors to revise the letter auditing tool.

The Plan submitted the following documents:

- Plan Health Net's internal acknowledgment letter compliance report ratings
- A copy of the relevant section of the minutes of the Member Services and A&G Meeting
- A sample Late Member Issue Submission Report
- A copy of the March 22 e-mail notification to the Classification Team
- A copy of the old quality of care grievance template letters
- A copy of the two new quality of service grievance template letters
- A copy of Training material, including agenda, sign-in sheets and handouts
- A copy of the Grievances and Appeals Department's letter auditing tool
- A sample of actual audits

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has implemented appropriate corrective actions and has demonstrated sustained improvement from February through April 2005 regarding its acknowledgment of grievances and appeals within five calendar days of receipt. Additionally, the Department's review of the audit sample submitted by the Plan demonstrated that the Plan is providing enrollees with clear and concise explanations for its decisions.

Deficiency 2: The Plan does not appear to immediately notify enrollees of their rights to notify the Department in times of urgent grievances. [Rule 1300.68.01(a) (4), Section 1368.01(b)]

Documents Reviewed:

- 10 urgent appeal files from the time period July 2004 to December 2004

Department Findings: The Department reviewed the same 10 urgent appeals cited in Deficiency 1 above. Table 4 summarizes the Department's findings:

TABLE 4

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Urgent Appeal files	10	Immediate notification of a member of his/her right to contact the Department.	0 (100%)	10 (100%)

The Plan officer stated that staff members verbally notify the enrollee of his/her right to contact the Department upon receipt of an urgent grievance but conceded that such notification is not documented appropriately and consistently.

Implications: In accordance with Rule 1300.68.01(a) (4), an enrollee is not required to participate in a plan's grievance process prior to applying to the Department for review of the urgent grievance. Hence, an enrollee must be informed of his/her right to contact the Department upon filing for an urgent grievance so that he/she may decide whether or not to participate in the Plan's grievance process.

Corrective Action: The Plan shall submit evidence that, upon receipt of urgent grievances, it immediately notifies the enrollee of his/her right to contact the Department.

Plan's Compliance Effort: The Plan stated that its A&G Department has developed, implemented and measured a revised procedure for compliance with the requirement to immediately notify members of their right to notify the DMHC of the expedited appeal. The Classification Team that handles all expedited appeal cases received communications regarding the need to immediately notify the member of the right to contact the DMHC and formal training was conducted. A desktop procedure, Expedited Appeal—Member Notification was also created specific to the process. The Case Audit Tool was also revised to properly monitor compliance during case audit. A random sampling of expedited cases received from February to April 2005 was reviewed to ensure that the notification is being provided and documented in the case file.

The Plan submitted the following documents:

- A copy of the e-mail notification to the DMHC
- A copy of a desktop procedure, Expedited Appeal—Member Notification
- A copy of the training materials used to educate associates
- Sample of expedited cases received from February to April 2005
- A copy of a Revised Case Audit tool

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has implemented appropriate changes in its procedures. A review of the sample expedited cases demonstrated that the revised procedures have resulted in immediate notification of enrollees regarding their right to notify the Department in times of urgent grievances.

ACCESS and AVAILABILITY

Deficiency 3: The Plan does not have a documented system for monitoring and evaluating the availability of providers that includes a system for addressing suspected problems. [Rule 1300.67.2(f)]

Documents Reviewed:

- GeoAccess Reports, 2004, 2003, 2002
- Primary Care Physician Linkages Reports (quarterly), 2004, 2003, 2002
- Primary Care Physician Availability Quarterly Reports, 2004, 2003, 2002
- Integrated Analysis for Accessibility of Services, 2003, 2002
- Provider Oversight Committee (POC) Minutes, March 2003, Integrated Access Analysis
- POC Minutes - September, October, November and December 2003; January 2004
- POC Minutes, March 2004, Integrated Access Analysis - Pages 6 and 7
- Member Satisfaction Committee (MSC) Minutes, March 2003
- Appeals and Grievances QOS Trend Analysis reports, 2004, 2003, 2002

Department Findings: While the Plan has established a system for monitoring the availability of providers and analyzing gaps in the delivery network, it has not provided evidence that it takes actions to ensure that services are available to its enrollees when gaps in delivery are identified.

The Plan performs GeoAccess analyses annually, monitors complaints quarterly, and administers the CAS and CAHPS enrollee surveys. No significant issues have been identified using complaint data or the surveys; however, the July 2003 GeoAccess analysis identified the following areas of non-compliance with the Plan's standards for availability of network providers throughout the various geographic areas in which the Plan operates:

- Nine (9) urban counties did not meet the standard for one or more specialties
- 14 rural counties did not meet the primary care physician standard
- 24 rural counties did not meet the hospital standard
- Oncology was below the GeoAccess standard in both urban and rural areas

The 2003 analysis with the identified outliers was first presented to the POC in September 2003. The analysis was presented again at the October, November and December 2003 and January 2004 POC meetings. No discussion of causal analysis or interventions was documented in the minutes of any of the meetings. The January 2004 POC minutes stated that the analysis was provided to Provider Network Management for interventions. When Plan staff was asked for further documentation, they stated that there was no additional documentation of the 2003 GeoAccess analysis.

When asked if any interventions had been implemented as a result of the 2003 GeoAccess analysis, Plan staff reported that no interventions had been implemented because the 2003 GeoAccess methodology did not represent provider availability accurately. They stated that the methodology was based on centroid measurements, which calculated availability using the geographic center of a zip code polygon with an assigned latitude and longitude. Based on this issue, according to staff, the Plan disregarded the 2003 results. Plan staff were not able to produce documentation that confirmed that interventions were not taken because of what they deemed to be a questionable methodology.

The 2004 GeoAccess analysis was completed in August 2004 using a new methodology that calculated the distances between two addresses based on the latitude and longitude of each address. The 2004 analysis indicated that all measures were above the Plan's goal of 90% compliance with its standards with the exception of Emergency Rooms. Provider Network Management staff are currently reviewing the data for recommendations to be presented to the POC; however, no interventions had been taken as of the date of the Department's visit on January 31-February 3, 2005.

Implications: An adequate number and geographic distribution of providers is essential to ensuring that care provided to enrollees meets accepted standards of care in a timely manner. Failure to ensure that an adequate number and distribution of providers are available may result in enrollees experiencing delays in receiving care, which may contribute to potential negative outcomes.

Corrective Action: The Plan shall submit evidence that it has established an effective mechanism for evaluating the availability of providers that includes addressing suspected problems. Specifically, the Plan shall:

(1) Submit a corrective action plan that addresses the outliers identified as a result of the 2004 GeoAccess analysis. The corrective action plan shall include, but not be limited to, interventions, regular re-measurements to ensure that the corrective actions are effective and improvements are sustained, assignment of responsibilities and timeframes for activities.

(2) Submit results that demonstrate the effectiveness of the corrective action plan. If the process has not yet been fully implemented and re-measurements conducted by the time the Plan submits its response, submit any interim results that are available and the timelines the Plan has scheduled for implementing outstanding interventions and re-measuring results.

Plan's Compliance Effort: The Plan stated that it formed a multi-disciplinary Access and Availability work group with participants from Quality Improvement, Provider Network

Management, Research Analysis, Appeals & Grievances, Member Services, Provider Data Management, and Program Accreditation. The work group began meeting in February 2005 to review and develop actions for several access and availability issues, including follow-up to the 2004 GeoAccess Survey. The decisions of the work group include:

A. Complete follow-up and actions for the 2004 GeoAccess Survey.
B. Form a planning work group for the 2005 Integrated Availability Survey (previously called GeoAccess Survey) to determine review methodologies, goals, timetable and follow-up strategies.
C. Review and assess current access and availability monitoring activities; revise Policy and Procedure QM #120: Access and Availability of Providers and Practitioners accordingly.
D. Annually update ER services and hospital bed capacity from online OSHPD data and assess data as part of the Integrated Availability Survey.

Provider Network Management completed a follow-up assessment to the measures that did not meet Medicare goals in Kern County from the 2004 GeoAccess Survey and submitted a report to the POC in April 2005. Provider Network Management determined that, although there are a few ZIP Codes that do not have hospitals or laboratories within the 15-mile/30-minute standard, there does not seem to be a significant availability issue for the 6,543 Medicare members in Kern County. Some of the ZIP Codes presented as outliers for hospitals do meet criteria; therefore, the process will be reviewed in conjunction with the 2005 GeoAccess Survey to determine why such ZIP Codes would be identified. The Plan will continue to monitor grievance data to validate the conclusions and will re-measure hospital and laboratory availability in 2005.

The Plan also stated that a planning meeting of the multi-disciplinary Access and Availability work group was conducted on May 23, 2005 to discuss the 2005 Integrated Availability Survey and that a copy of the work group's report will be presented to the POC in June 2005. The 2005 GeoAccess Survey is in process and will be completed and reported to the POC by October 2005.

The Plan submitted the following documents:

- Reports from the work group meeting in February 2005
- Minutes of the Meeting: April 13, 2005
- Policy/Procedure #QM-120: Access and Availability of Providers and Practitioners
- A copy of the report submitted to the Provider Oversight Committee in April 2005
- A copy of the work group's report of the May 23, 2005 meeting

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has implemented corrective actions; however, the Plan was unable to fully implement all of its proposed corrective actions and to demonstrate the

effectiveness of these actions within the 45 day-response period. During the Follow-up Review, the Department will review the results of the 2005 Integrated Availability Survey and will review documentation of the Plan's analysis and follow-up.

UTILIZATION MANAGEMENT

Deficiency 4: For retrospective reviews, the Plan does not consistently complete its review within 30 days of receipt of medical information necessary to make a determination. [Section 1367.01(h)(1)]

Documents Reviewed:

- 10 files for retrospective denials from the period June through November 2004

Department Findings: The Department reviewed the files of 10 cases that were retrospectively denied by the Plan and noted that only five (5) were reviewed within 30 days of receipt of medical information necessary to make a determination (see Table 5).

TABLE 5

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Retrospective denial	10	Review within 30 days of the receipt of complete information	5 (50%)	5(50%)

Implications: Timely processing of reviews is an essential component of a fair and effective utilization management system. Untimely communication of denial decisions may hinder enrollees' exercise of grievance/appeal rights and/or may result in an enrollee or provider continuing with a course of treatment or services which will later be denied, resulting in financial cost to that enrollee or provider.

Corrective actions: The Plan shall provide evidence that it processes retrospective reviews within 30 days of receipt of all information that is necessary to make a determination. The Plan shall implement a monitoring system to investigate and report regularly on the length of time that it takes to request records, and the system for aging of requests so that records are received in a timely fashion, the length of time that it takes to send records for medical review after they are received, and the length of time that it takes to make a decision once sufficient information has been received. The Plan shall develop and implement a corrective action plan to correct any systemic issues that are identified in its evaluation of the problem. A re-evaluation shall be made to ensure that the corrective actions, if any, are improving the process.

Plan's Compliance Effort: The Plan stated that it audited the Retrospective Medical Claims Review denial log for 100% of the denied cases received for three (3) months (2/1/05-4/30/05) for timeliness. The average for the three (3) months was 81% compliance. Of the total 97 cases, 18 were out of compliance. Of those out of compliance, 83% were under review over 30 calendar days due to systemic process issues. The 83% was comprised of requests originating from the Claims Operations Department (28%) and the Customer Contact Center (55%). The remaining

17% were due to nurses or Medical Directors in Medical Management not reviewing cases timely. Retrospective Medical Claims Review will continue to monitor compliance on a monthly basis and to identify root causes for cases that are found to be out of compliance.

The Plan stated that it implemented the following new or revised Retrospective Medical Claims Review documents on May 27, 2005 to improve the accuracy of data collection and to facilitate tracking and monitoring of timeliness:

1. Denial File/Letter Check List for the nurse and Manager to review each file.
2. Denial Letter Preparation Form, which was revised to include medical record request and received dates.
3. Medical Director Review Summary form, which was revised to include medical record request and received date.
4. Denial Log, which was revised by adding columns to track request and received dates.
5. Medical Information Requests log to track requests and receipts of medical information.
6. Desktop Procedure that outlines the process to request, receive and monitor the request/receipt of additional medical information.
7. Workflow created to exhibit new procedure for additional medical information requests.
8. Request for Medical Information letter to request information from providers and members.

The Plan stated that the Retrospective Medical Claims review staff and Medical Directors were re-trained concerning new procedures and documentation. Additionally, a cross-functional process improvement team would be established by July 1, 2005 to address timeliness of routing claims for retrospective review. This team will conduct barrier analysis, determine interventions and report status to appropriate committee(s).

The Plan submitted the following documents:

- A Retrospective Medical Claims Review Denial File/Letter Check List
- A Retrospective Medical Claims Review Denial Letter Preparation Form
- A Retrospective Medical Claims Review Medical Director Review Summary form
- A Retrospective Medical Claims Review Denial Log
- A Retrospective Medical Claims Review Medical Information Requests log
- A copy of the Desktop Procedure #MC-124: Retrospective Medical Claims Review Medical Information Request form
- A copy of a Workflow created for Retrospective Medical Claims Review staff
- A Request for Medical Information letter
- Documentation of training concerning new procedures and documentation for better compliance results on May 27, 2005

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has implemented corrective actions; however, the Plan was unable to fully demonstrate the effectiveness of these actions within the 45 day-response period. While progress appears to have been made toward ensuring that review of all denials is completed within 30 days of receipt of all medical information necessary to make the determination, the Plan's internal review confirms that this requirement has not yet been met. During the Follow-up Review, the Department will review a sample of retrospective denials to determine whether the Plan is consistently completing its review within required timeframes.

Deficiency 5: The Plan does not adequately ensure that delegated providers follow the prudent layperson standard when reviewing emergency services. [Sections 1367.01(a) and 1371.4(c)]

Documents Reviewed:

- Five (5) files for emergency services denied by delegated providers from the period June through November 2004

Department Findings: The Department examined the tool the Plan uses for auditing its utilization management (UM) delegated providers and found that the tool is not sufficiently thorough to adequately oversee the delegates' denial process for emergency services. The Plan conducts a review of the delegate's policies and procedures; however, the Plan does not conduct case file review to assess whether the policies and procedures are being followed.

The Department reviewed five (5) emergency service denials made by delegated providers. The Department found that the delegate appropriately applied the prudent layperson standard[1] in only three (3) cases. Table 6 summarizes the Department's file review findings.

TABLE 6

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Emergency denials	5	Use of lay person rule for emergency service review	3 (60%)	2 (40%)

In the two (2) emergency service denial cases that were found by the Department to be deficient, the first involved a patient with acute onset of severe epigastric (abdominal) pain and the second was a patient with sever migraine headache and vomiting. The UM Surveyor, (a licensed California Medical Doctor), felt that both were situations where the enrollee was in considerable pain and that a prudent layperson would agree that emergent evaluation and treatment would be in the best interest of the enrollee. These two cases were discussed with the Plan representative,

[1] A standard where the judgment of a medically untrained individual is used as the basis for the urgency or emergent nature of any condition.

and it was agreed that this qualified as a situation where a prudent layperson would agree that this was an emergency situation.

Implications: Should a Plan choose to delegate its UM responsibilities, the Plan is responsible for ensuring that these responsibilities are properly carried out by its delegates (i.e., that denials are not made inappropriately). To do this, the Plan must provide adequate oversight of the delegate and must require corrective actions when problems are discovered.

Corrective Actions: The Plan shall submit evidence that it has sufficiently addressed the oversight of delegated UM emergency denials. The Plan shall submit evidence that it has improved or revised the audit tool to evaluate every UM delegated entity for application of the prudent layperson rules for emergency service denials. The Plan shall submit evidence that it is measuring UM delegated entities' compliance to these standards and that appropriate corrective actions are implemented by the delegated entities, if needed.

Plan's Compliance Effort: The Plan stated that it utilizes its Provider Delegation Assessment Tool (PDAT) to evaluate its delegated Participating Physician Groups (PPGs) adherence to all regulatory and accreditation standards, including application of the "prudent layperson" rules for emergency service denials. The Plan has enhanced the instructions for the 2005 PDAT File Review to include an example of application of the prudent layperson standard and modified the instructions to the Medical Program Manager to discuss the file in question with the appropriate personnel at the time of the onsite file review.

The Plan stated that it has increased oversight of Emergency Room (ER) denials by requiring both its Claims auditors and Medical Program Managers to retain copies of ER denial files and to review these files with their counterparts and the PPG Medical Director post audit as necessary. The Plan will review ER denials that have been appealed to the Plan from PPG membership, identify PPGs that inappropriately deny ER visits, and re-educate them when necessary on the prudent layperson standards. These files are reviewed quarterly and shared with Medical Program Managers and Medical Directors as appropriate. A copy of the A&G Department response to the appeal is also sent to member's PPG.

The Plan also noted that an update had been sent to delegated medical groups on January 30, 2004 regarding "prudent layperson" standards and ER treatment and claims.

The Plan submitted the following documents:

- A copy of the 2005 PDAT File Review: Guidelines for Reviewers
- A memo to the Provider Oversight staff
- A sample log of appeals for ER denials for 4th quarter 2004
- A copy of the Provider Update #04-015: PPG Responsibility for Emergency Services and Emergency Services Claims

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has implemented appropriate monitoring and that it has been conducting appropriate corrective actions when necessary. The Plan, however, did not provide a sample of cases or audit results subsequent to its interventions to demonstrate that inappropriate denials were no longer occurring.

Although the Plan has demonstrated that corrective actions have been implemented, it was unable to demonstrate the effectiveness of these actions within the 45 day-response period.

During the Follow-up Review, the Department will review a sample of emergency service denials to assess the effectiveness of the Plan's interventions toward ensuring that its PPGs appropriately apply the prudent layperson standard.

SECTION III. SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan. The Department will conduct a Follow-up Review of the Plan and issue a report within 18 months of the date of this Final Report. (See Appendix H for detailed information regarding the Follow-up Review.)

A P P E N D I X A

OVERVIEW OF THE MEDICAL SURVEY PROCESS

The medical survey is a comprehensive evaluation by the Department of a health plan's compliance with the Knox-Keene Act and its resulting performance in meeting the health needs of plan enrollees. The survey includes an on-site meeting, a review of documents and interviews with the plan's staff. It also includes a review of the plan's oversight of the plan's provider network.

Generally, the Department evaluates a plan's performance in four major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees. During the medical survey, the Department evaluates a plan's quality management program, including:

- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits;
- Overall performance of the plan in meeting the health needs of enrollees; and
- Mechanisms for credentialing and peer review.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner. The Department regards a plan's grievances and appeals process as a core mechanism through which enrollees can exercise their rights should there be a need to resolve problems with their HMO. During the medical survey, the Department evaluates a plan's grievances and appeals system, including:

- Design, implementation and effectiveness of the Grievances and Appeals system;
- Procedures for addressing the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities such as those with visual or other communicative impairment;
- Documentation, investigation and resolution of all forms of grievances and appeals;
- Notification to enrollees, their designees and providers of the disposition of the grievances and appeals; and
- Compliance with timeliness standards.

(3) **Access and Availability of Services –** Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas and that services are available without delay that may be detrimental to enrollees' health. During the medical survey, the Department evaluates a plan's:

- Procedures for obtaining health care services;
- Procedures for monitoring and ensuring geographic access;
- Procedures for monitoring and ensuring appointment availability; and
- Overall performance in meeting established access and availability standards.

(4) **Utilization Management** – Each plan manages the utilization of medically necessary services through a variety of cost containment mechanisms while ensuring access and quality care. During the medical survey, the Department evaluates a plan's utilization management program, including:

- Procedures for reviewing authorization requests and regulating utilization of services and facilities;
- Compliance with notification and timeliness standards;
- Use of appropriate criteria or clinical guidelines to guide authorization decisions; and
- Use of utilization data to identify and analyze patterns and trends for potential over-utilization or under-utilization of services and to institute corrective actions as necessary.

Following a routine medical survey, the Department provides a plan with a Preliminary Report of its deficiency findings. A plan is required to respond in writing within 45 days of receipt of the Preliminary Report and to submit evidence that the deficiencies have been corrected within the same 45-day response. For those deficiencies that cannot be corrected within the 45-day response period, a plan is required to submit a corrective action plan for Department approval. The Department then provides a Final Report to the plan and makes the report available to the public by mail or on its website (www.dmhc.ca.gov) within 180 days of the last date of the onsite survey. The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response.

The Department conducts a Follow-up Review and issues a report within 18 months of the date of the Final Report to determine whether uncorrected deficiencies identified in the Final Report have been corrected. The Department then provides a Follow-up Report, which contains the Department's determination concerning the outstanding deficiencies. If deficiencies identified in the Final Report remain uncorrected at the time of the Follow-up Review, a plan may be subject to disciplinary actions pursuant to Health and Safety Code 1380(i)(l). (See Appendix G for additional details on the reporting and response process.)

A P P E N D I X B

ENFORCEMENT ACTION(S)

Below is a list of Enforcement Action(s) taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

COMPLAINT # / CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 214903 **Citation(s):** Section 1368(a)(5), Rule 1300.68(g)	The Department determined that the Plan violated Section 1368(a)(5) by not providing a "clear and concise explanation of the reasons for the plan's response" to the enrollee grievance. The Department also determined that the Plan violated Rule 1300.68(g) which requires the plan to provide all medical records relating to the grievance or provide a statement that no such records were used in resolving the grievance.	February 18, 2005
Complaint No. 165834 186965 **Citation(s):** Section 1368.01(a), Rule 1300.68(d)(3)	In Complaint 165834, the Department determined that the Plan violated Section 1368.01(a) and Rule 1300.68(d)(3). An enrollee appealed the Plan's denial for services and the Plan subsequently upheld its denial. Approximately 54 days passed from the date of receipt to the date of the decision. In Complaint 186965, an enrollee grievance was received by the Plan on January 30, 2004, but due to a system routing error, was not received in the Appeals and Grievance Department. Approximately 69 days passed before the enrollee's grievance was resolved.	January 26, 2005
Complaint No. 156196 **Citation(s):** Section 1368.01(a), Rule 1300.68(d)(2)&(3)	An enrollee submitted a claim for reimbursement of health care services. The Plan acknowledged receipt of the enrollee's reimbursement request for those services, on October 14, 2003, by way of the Plan's acknowledgment letter, on January 20, 2004. In that letter the enrollee's grievance was not assigned to one of the Plan's representatives in the Grievance Department, at the time of receipt of this grievance in October 2003.	September 29, 2004
Complaint No. 160093 **Citation(s):** Section 1368.01(a), 1368(a)(B)(6) Rule 1300.68(a)(4)(A)	The Department determined that the Plan did not comply when resolving an enrollee's grievance within 30 days of the date of submission. The enrollee requested reconsideration of the Plan's denial of coverage for a medication, on September 5, 2003. The Plan's original denial for this medication was August 13, 2003; the Plan did not respond to the grievance until October 16, 2003 and denied the request again as not medically necessary. The Plan's response to the reconsideration request was subject to the same 30-day time period as the original grievance. Because reconsiderations are multiple internal levels of grievance resolutions, they have to be completed within 30 days of the Plan's receipt of the grievance.	September 29, 2004

COMPLAINT # / CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 143455, 142995 **Citation(s):** Section 1368.01 (a), Rule 1300.68 (d)(3)	The Department determined that the Plan did not comply when resolving an enrollee's grievance within 30 days of the date of submission. In Complaint 143455 it took 48 days and in Complaint 142995 it took the Plan 36 days to resolve the grievance.	July 22, 2004
Complaint No. 121738 120452 **Citation(s):** Section 1368(a)(5)	In Complaint 121738, the Plan's grievance denial letter dated 6/26/03 did not include the applicable EOC provisions for a coverage denial. The letter misstated the reconstructive surgery section. In Complaint 120452, the enrollee (who suffered from right side nasal obstruction) made a request for surgery for the replacement of nasal cartilage. The Plan denied this in a letter dated 6/24/03. The denial letter was not clear and concise and failed to include criteria or guidelines for a medical necessity denial.	June 14, 2004
Complaint No. 126558, 124913, 121376 **Citation(s):** Section 1368.01(a) Rule 1300.68(d)	The Department concluded that, for Complaint Numbers 126558, 124913, and 121376, the Plan failed to provide its written resolution within 30 days. The Plan exceeded the limits by amounts ranging from four to eight days.	May 13, 2004
Complaint No. 128460 **Citation(s):** Section 1368,01 (a), 1368.02(b) Rule 1300.68(d)(3), 1300.68(d)(7)	The Department determined the Plan failed to resolve an enrollee's grievance within 30 days and found that two of Health Net's letters failed to recite the updated statutory paragraph.	April 19, 2004

A P P E N D I X C

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

The table below summarizes the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	Full Service Health Plan		
Service Area(s) *(Counties, in full or in parts)*			
Alameda	Mono	Sacramento	Santa Clara
Contra Costa	Merced	San Bernardino	Santa Cruz
El Dorado	Monterey	San Diego	Solano
Fresno	Napa	San Francisco	Sonoma
Kern	Nevada	San Joaquin	Stanislaus
Kings	Orange	San Luis Obispo	Tulare
Los Angeles	Placer	San Mateo	Ventura
Madera	Riverside	Santa Barbara	Yolo

Number of Practitioners	**Primary Care**	**Specialty Care**	**Affiliated Medical Groups or IPAs**
	22,142	22,530	169

Number of Enrollees as of January 2005	**Product Lines**	**Enrollees**
	Commercial HMO	1,014,650
	Commercial POS	323,307
	Total	**1,337,957**

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The table below presents a brief overview of the Plan's operations in each of the four (4) program areas that were examined during the Department's Routine Medical Survey.

OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
QUALITY MANAGEMENT	• The Quality Improvement Committee (QIC) has primary responsibility for oversight of the Quality Management (QM) program. The QIC delegates some responsibilities to subcommittees, including: ➢ Peer Review Committee; ➢ Credentialing Committee; ➢ Pharmacy and Therapeutics Committee; ➢ Medical Management Committee; and ➢ Member Satisfaction Committee • Through the QIC and its subcommittees, primary care providers and specialists from a wide variety of specialties provide input to Plan policy development and decision-making. • The QM program is directed by the VP and Sr. Medical Director, QI & Clinical Informatics. • QM activities are guided by a thorough QM Program Description, policies and procedures that detail key QM activities, and an annual Work Plan with mid-year updates. • The Plan tracks and analyzes the quality of its medical care and its service provision using a variety of strategies, including: ➢ Annual epidemiological analysis; ➢ Review of individual grievance cases and analysis of grievance patterns and trends; ➢ Production of HEDIS and other performance indicators; ➢ Member Satisfaction surveys; ➢ On-site visits to providers; and ➢ Identification and review of cases with clinical triggers/sentinel events. • Where indicated, the Plan identifies individual providers and/or issues for improvement, designs and implements interventions to improve care and regularly re-measures to assess progress.

GRIEVANCES AND APPEALS	• Plan Policy/Procedure #GA-101 contains policies and procedures which guide the process of enrollee grievances and appeals. The grievances/appeals process includes provisions to receive, summarize, investigate, resolve and notify enrollees of the Plan's determinations. • The Plan's Chief Medical Director has oversight responsibility for the grievances and appeals process. The day-to-day management of grievances and appeals operations is delegated to the Director of Appeals and Grievances. • Enrollees have the right to voice and/or file a concern about the care and services received from the Plan, its participating providers, practitioners and participating provider groups. Enrollees may file grievances and appeals verbally, in writing, via e-mail, via the Plan's Internet website, or by completing the Grievance Form within 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction. • Medical necessity appeals are reviewed by an Appeals and Grievances Medical Director who has no previous involvement in the initial determination. • The grievances and appeals process is no more than a 30-calendar day process from the date the initial request was received by the Plan. Plan policy requires that a letter be sent to the enrollee before the 30th calendar day informing the enrollee of the reason if a case is placed in a pended status. If the case exceeds the 30-day time limit, a letter is sent to the enrollee before the 30th calendar day informing the enrollee of the reason for the pended status • The grievances and appeals process addresses the linguistic and cultural needs of the enrollees, as well as the needs of enrollees with disabilities. The Plan provides assistance, including but not limited to translation of grievances and appeals procedures, forms, and Plan responses to issues. The Plan also provides access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.

ACCESS AND AVAILABILITY OF SERVICES	• The plan has established access and availability standards to guide its performance in areas such as appointment availability, geographic distribution, hours of operation, and after-hours services. • The Plan monitors its compliance to its standards through: ➢ Member complaints and grievances; ➢ Member satisfaction surveys; ➢ Analysis of disenrollments; ➢ Analysis of PCP transfers; and ➢ GeoAccess studies and mapping of providers, hospitals and ancillary services • The Provider Oversight Committee (POC) monitors and assesses provider compliance with regulatory requirements pertaining to the delivery of care and service to enrollees.
UTILIZATION MANAGEMENT	• The Commercial +Medicare UM/QI Committee is responsible for the oversight of Health Net's utilization/care management process. This committee reports to the Health Net Quality Improvement Committee. • The Chief Medical Director is responsible for implementing the Utilization/Care Management Programs. • The UM process is highly delegated with 94% of enrollees delegated to participating medical groups with UM oversight. • There are clear criteria for UM decision-making, and a clear process to update those criteria with periodic approval from actively practicing providers. • Prospective and concurrent authorizations are generally processed in a timely manner with proper denial notification sent to the requesting provider and the enrollee. • The Plan does not process its retrospective authorizations in a timely manner. • There is an active oversight and QM review of the UM process. • Prescription drug requests are processed in a timely manner with proper denial notification sent to the requesting provider and the enrollee. • The Plan does not deny any Emergency department authorization, however the oversight of the delegated participating groups for Emergency department denials is inadequate to protect the enrollee from inappropriate denials.

A P P E N D I X D

LIST OF SURVEYORS

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Diane Richards, RN	Nurse Evaluator II
David Weinberg	Staff Health Care Service Plan Analyst

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Rose Leidl, RN, BSN	Project Manager, Grievances & Appeals Surveyor
Bernice Young	Program Director, Grievances & Appeals Surveyor
Patty Nelson MS, RN, CPHQ	Access & Availability of Services Surveyor
Laurence Ikeda, MD	Utilization Management Surveyor
Patricia Allen, M.Ed.	Quality Management Surveyor

A P P E N D I X E

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative office from January 31 through February 3, 2005.

HEALTH NET OF CALIFORNIA	
Mark daShiell, RN	VP, Health Care Services
Sandy Tuttobene, RN	Director Appeals & Grievances
Lin Yong, MD	VP, Integrated Medical Services
Janet Kirkpatrick, MD	Medical Director
Lance Lang, MD	P. Sr. Med Dir QI
Peggy Haines, RN	VP QI & Compliance
Janet Johnson-Yosgott	Sr. Health Improvement Specialist
Pam Gregg	Manager, Program Acc
Michael Catello	Manager, Credentialing
Rita Lonzo	Director, Provider Oversight
Karen Bowling	Provider Oversight
Terry Poplawski, RN, NP	Quality Improvement
David Koury	VP, Provider Network Management
Juanell Hefner	VP, Call Centers

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
A&G	Appeals and Grievances
CAHPS	Consumer Assessment of Health Plans
CAP	Corrective Action Plan
ER	Emergency Room
HMO	Health Maintenance Organization
MSC	Member Satisfaction Committee
OSHPD	Office of Statewide Health Planning and Development (California)
PCP	Primary Care Provider
PDAT	Provider Delegation Assessment Tool
POC	Provider Oversight Committee
QIC	Quality Improvement Committee
QM	Quality Management
UM	Utilization Management

A P P E N D I X G

APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiencies:

GRIEVANCES and APPEALS

Deficiency 1: The Plan does not consistently:
(a) acknowledge receipt of appeals within five (5) calendar days of Plan receipt of the grievance/appeal ; and
(b) provide the enrollees with a clear and concise explanation for the Plan's decision.

Citation:
Rule 1300.68(d)(1)
The Plan shall respond to grievances as follows:
A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8).

Section 1368(a)(4)
Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Deficiency 2: The Plan does not appear to immediately notify enrollees of their rights to notify the Department in times of urgent grievances. [Rule 1300.68.01(a) (4), Section 1368.01(b)]

Citation:
Rule 1300.68.01(a) (4)
(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:
(4) No requirement that the enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

Section 1368.01(b)
The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the Department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the Department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

ACCESS and AVAILABILITY

Deficiency 3: The Plan does not have a documented system for monitoring and evaluating the availability of providers that includes a system for addressing suspected problems.

Citation:
Rule 1300.67.2 (f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

UTILIZATION MANAGEMENT

Deficiency 4: For retrospective reviews, the Plan does not consistently complete its review within 30 days of receipt of medical information necessary to make a determination.

Citation:
Section 1367.01(h)(1)
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonable necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law.]

Deficiency 5: The Plan does not adequately ensure that delegated providers follow the prudent layperson standard when reviewing emergency services.

Citation:
Section 1367.01(a)
A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

Citation:
Section 1371.4(c)
Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

A P P E N D I X H

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following paragraphs provide detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. The table below summarizes the survey activities and the corresponding timeframes.

MEDICAL SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Notification Letter and Request for Documents	Prior to on-site visit
Routine Survey On-Site Visit Conducted	At least once every three (3) years
Preliminary Report due from the Department to the Plan	Within 60-80 days from last day of on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit
Follow-up Review Conducted	Anytime within 16 months of date Final Report issued to the Public File
Follow-up Report due from the Department to the Plan	No later than 18 months from the date of the Final Report issued to the Public File
Response from Plan to Department on any matters in Follow-up Report	Within 10 calendar days from receipt of Follow-up Report. Response is included in Public File with Follow-up Report
Follow-up Report due to the Public File [Section 1380(i)(2)]	No later than 18 months from the date of the Final Report issued to the Public File

Survey Preparation

The Department conducts a routine medical survey of each licensed health care service plan at least once every three (3) years in order to evaluate the plan's compliance with the Knox-Keene Act. Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-site Visit

During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Within 60-80 days of the onsite visit, the Department provides the Plan with a Preliminary Report, which details its survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey. The Final Report to the public will be placed on the Department's website: http//www.dmhc.ca.gov/library/reports/med_survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.

Follow-up Review

The Department will conduct a Follow-up Review of the Plan and issue a Follow-up Report within 18 months of the date of the Final Report to determine whether all deficiencies that were uncorrected at the time of the final report have been corrected [see Health and Safety Code Section 1380(i)(2)]. Please note that the Plan's failure to correct deficiencies identified in the survey report may be grounds for disciplinary action against the plan as provided by Health & Safety Code section 1380(i)(1).

A P P E N D I X I

LIST OF PROVIDERS INTERVIEWED

The following are provider representatives who were interviewed during the on-site survey at the Plan on February 2, 2005.

REGAL MEDICAL GROUP	
T. K. Desai, MD	Medical Director
Pat Hipsman, RN	VP, UM
Mary Inglis, RN	VP, QM
Don Miller	Credentialing Manager
GLENDALE MEMORIAL MEDICAL GROUP	
Francisco Federico, MD	Medical Director
Robert Feldman, RN	Health Services Director
Dala Maloney	Credentialing Manager
PHYSICIANS ASSOCIATES OF THE GREATER SAN GABRIEL VALLEY	
Joseph Daniels, MD, MBA	Medical Director
Yolanda Denson RNC-NP	Director of Health Services
Stephanie Bamford, RN, BS	Director of Quality Management
Harry Magnes, MD	Director of Quality Management
Lynn Nguyen, LVN	Supervisor of QM and Credentialing